The following are my suggestions for your consideration regarding amendments to ORS 675.850.

The American Counseling Association's *2014 ACA Code of Ethics* (https://www.counseling.org/resources/aca-code-of-ethics.pdf) is a central standard of in the field of counseling. *2014 ACA Code of Ethics* §A.1.a. Primary Responsibility states "The primary responsibility of counselors is to respect the dignity and promote the welfare of clients" (pg. 4). If any feature of the "gender-affirming care" model conflicts with this *primary responsibility*, the client's *dignity* and *welfare* must be preserved over ideological dictates. For a counselor to do otherwise would be to hold a *model of care* or a *theory* over a client's welfare. *No*single counseling model, not Cognitive Behavioral Therapy, not Jungian psychoanalysis, not transpersonal therapy, *no therapy or theory* can override this primary responsibility of a counselor: "gender-affirming care" is no exception. The law must protect a counselor's primary responsibility.

2014 ACA Code of Ethics §A.2.d. Inability to Give Consent states, in part, that "Counselors recognize the need to balance the ethical rights of clients to make choices, their capacity to give consent or assent to receive services, and parental or familial legal rights and responsibilities to protect these clients and make decisions on their behalf" (p. 4). If a client is a minor and/or has conditions that limit the client's capacity to consent, the counselor must *balance* these factors with family involvement and the need to protect the client. The law *must* protect a counselor's ability to make such decisions and involve family or other parties if it is called for, regardless of what "gender affirming care" might admonish a counselor to do.

2014 ACA Code of Ethics §A.4.a. Avoiding Harm states that "Counselors act to avoid harming their clients, trainees, and research participants and to minimize or to remedy unavoidable or unanticipated harm" (p. 4). If a counselor believes that his or her actions may *harm* a client, the counselor is *ethically forbidden*from engaging in those actions. Setting any legal standard that a counselor is *required* to act in a way that harms his or her client would directly contradict current ethical guidelines and which could put a counselor in a position where he or she must break the law to keep his or her license, or to give up his or her license to avoid breaking the law. The law must protect a counselor's ability to *not engage in actions that harm the client*: "gender-affirming care" *cannot* coerce a counselor into knowingly harming a client.

2014 ACA Code of Ethics §A.4.b. Personal Values states, in part, that "Counselors are aware of—and avoid imposing—their own values, attitudes, beliefs, and behaviors" (p. 5). If a client is ambivalent about his or her identity in some meaningful sense, *affirming* any one particular interpretation or polarity would be a way of the counselor *imposing* his or her own values and therefore violating an ethical requirement of the profession. "Gender affirming care" pressures counselors to "affirm" precisely during times when the client is unsure about some aspect of their identity. A counselor is not a guru: the law must protect *clients* from counselors who might *impose their own views*.

A popular textbook for counseling trainees is

Capuzzi, D., Stauffer, M. D. (2016). Counseling and Psychotherapy: Theories and Interventions, 6th Edition. John Wiley & Sons.

On page 1 of this textbook: "The helping relationship is the foundation on which the process of counseling and psychotherapy is based. It is not possible to use the concepts and associated interventions of a specific theory unless such applications are made in the context of a

relationship that promotes trust, insight, and behavior change." Later, "The helping relationship is the foundation on which the process of counseling or psychotherapy rests" (p. 20). The book goes on to describe the six *core conditions* of the helping relationship, one of which is *genuineness or congruence*: "Genuineness and congruence describe the ability to be authentic in the helping relationship (D. W. Sue & Sue, 2013). The ability to be real as opposed to artificial, to behave as one feels as opposed to playing the role of the helper, and to be congruent in terms of actions and words are further descriptors of this core condition (Kolden, Klein, Wang & Austin, 2011)" (p. 10). One of the ways the textbook describes for a counselor to generate congruence: "… present one's thoughts, feelings, and actions in a consistent, unified, and *honest* manner" (italics mine) (p. 10).

In other words, the helping relationship is foundational in all counseling, *regardless* of what paradigm the counselor is using. The helping relationship depends on *congruence*: the client *must trust the counselor* and the counselor *must be honest with the client to justify that trust*. If a client gets the sense that the counselor is *lying* to him or her, the entire counseling enterprise might be in jeopardy. "Gender-affirming care" admonishes the client to *affirm* the "gender identity" of the client, whether or not the counselor agrees with the client or even believes that "gender identity" is a meaningful term. The law *must protect* a counselor's freedom to be *honest* with the client. If a law requires a counselor to affirm an idea the counselor does not hold, in other words, to *lie to the client*, the very foundation of the counseling enterprise, the helping relationship, is at risk.

Arguably, the single most important reference in all of the mental health field is

Association, A. P. (2022). *Diagnostic and Statistical Manual of Mental Disorders, Text Revision* (DSM-5-TR), 5th Edition.

The law *must* protect the freedom of counselors and other mental health professionals to use DSM-5-TR according to professional standards. "Gender-affirming care" must not infringe on a mental health practitioner's ability to use *whatever* diagnoses that professional deems fit, according to current best practices and the technical standards outlined in DSM-5-TR. In particular, two diagnoses that mental health practitioners *must* maintain the ability to use with clients are: Delusional Disorder (F22) (p. 104) and Factitious Disorder Imposed on Self (F68.10) (p. 367). "Gender-affirming care" seems to assume that a client is definitely seeing the situation clearly (i.e., is not delusional) and is being totally honest with the mental health practitioner about the client's symptoms. Delusional Disorder (F22) and Factitious Disorder Imposed on Self (F68.10) exist precisely because neither of these conditions can be guaranteed in any particular relationship between a mental health practitioner and a client, and, indeed, may be so pronounced in a given client that a *formal diagnosis* is called for. The law *must protect* a mental health practitioner's ability to use *all* diagnoses in the DSM-5-TR and more generally to assess whether any given client is delusional or lying about his or her symptoms.

I don't know how to formally reference legal documents, but here's the document to which I'll be referring:

EXPERT REPORT OF DR. JAMES CANTOR
PFLAG, INC., ET AL., Plaintiffs, v. GREG ABBOTT, ET AL., Defendants.
NO. D-1-GN-22-002569.
IN THE DISTRICT COURT OF TRAVIS COUNTY, TEXAS 459th JUDICIAL DISTRICT.

In this expert report, Dr. Cantor states that “The research has repeatedly demonstrated that once one explicitly acknowledges being gay or lesbian, one is only very rarely mistaken. That is entirely unlike gender identity, wherein the great majority of children who declare cross-gender identity cease to do so by puberty, as already shown unanimously by all follow-up studies” (p. 42). The *law must* protect the ability of all mental health professionals to *allow for the possibility that the client is mistaken*, particularly if that client is a child. Even if the client is not diagnosed as delusional and even if the client is being honest about his or her symptoms, the client may simply be making an error in judgement or perception. To preclude the possibility of errors in client judgement or perception would not only be absurd on its face, since clients are just fallible human beings, but would also go against Dr. Cantor’s report that, at least for children, their assessment of their “gender identity” is not just *possibly* false, but *likely* to be false.

In his report, Dr. Cantor describes the “gate-keeper model” (p. 44), in which a clinician methodically assesses the benefits and risks of different decisions with respect to the various interventions a client diagnosed with gender dysphoria might be considering. The law must protect the gate-keeper model, as described by Dr. Cantor in particular. More generally, the law must protect a mental health practitioner’s ability to weigh the risks and benefits of the various interventions that “affirmation” can entail.